Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Division of Senior and Disabilities Services
HCB Waiver Program
Notices of Action, Appeals and Hearings

Introduction
Alaska's Administrative Code (7 AAC 49) provides applicants for, and recipients of Medicaid waiver services, the right to:
1) Notice of adverse actions
2) An appeal of such adverse actions
3) A fair hearing
Specifically, 7 AAC 49 states that an opportunity for a hearing must be granted to any client whose request for an application is denied, whose claim to Medicaid services is denied or not acted upon with reasonable promptness, or whose benefits the division plans to modify or terminate.
Clients in process under the Waiver program, managed by the Division of Senior and Disabilities (DSDS), may experience lengthy processing time, denied level of care that results in denial of Medicaid waiver services, or have services or providers changed, modified or denied. They may also receive denials of Medicaid benefits from the Division of Public Assistance (DPA).
Notice of Adverse Action
DSDS and DPA have the responsibility to provide clients with timely written notice of intent to take action denying, suspending, reducing or terminating assistance. Such notices must include the basis (statute, regulation, and policy) for such action and notify the client of his/her right to a hearing. Care coordinators are sent copies of such notices.
Care Coordinators as Client Advocates
Care coordinators have a responsibility to serve as client advocates. In the event of a grievance, care coordinators are expected to offer assistance to the client throughout the process and/or to refer the client to appropriate sources of assistance.

The Formal Hearing Request
A request for a hearing may be made orally or in writing by the client, or by the client's representative, within 30 days of receiving a notice from DSDS or DPA of intended action. The request can be made to any employee of the Division of Senior and Disabilities Services or to the client's eligibility technician or other staff in the Division of Public Assistance.

Requests for hearings are forwarded to DHSS/Division of Health Care Services (DHCS), which has the responsibility for conducting fair hearings involving Medicaid issues. No later than 15 days after the receipt of a request, DHCS will schedule a hearing and notify the client in writing of the time, date and place of the hearing.

Client Assistance
Upon oral or written request from the client, Division of Health Care Services (DHCS) will provide assistance to the client in obtaining representation, preparing his/her case, and gathering witnesses and/or documents to be used in presenting his/her claim. The client may choose to represent him/herself or have a representative such as a care coordinator, guardian, attorney, friend or family member may be the client representative at the fair hearing.

Fair Hearing
A DHSS hearing officer will preside over the proceeding, listen to statements, review records/documents and render a decision no later than 90 days after the receipt by the division of the request for a hearing. The hearing officer will provide the decision to the client in writing. Information will be included to inform the client of his/her right to appeal the hearing officer's decision to the Director, Division of Senior and Disabilities Services.

DSDS Director's Review
The client must submit his/her appeal of the decision of the DHSS hearing officer to the DSDS Director within 15 days of receipt of the hearing officer's written decision. Appeal to the DSDS Director constitutes the final administrative action available to a client.

The DSDS Director must review the record of the hearing, the hearing officer's decision, and applicable laws, regulations, and policies, and render a written decision. This review must be completed no later than 10 days after receiving a client's request for review. The DSDS Directors' decision will be sent to the client in writing and will include a statement of the client's right to judicial review.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

Division of Senior & Disabilities Services

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) The types of grievances/complaints that participants may register:
Complaints/grievances may be made about any aspect of service provision and/or program compliance - including the quantity and quality of services received or failure of services to be provided

All HCB Agencies must maintain a complaint system as well as a participant satisfaction survey which allows for complaints and grievances. Thus, the first level of complaint by a recipient against a specific provider agency would be at this level. Recipients are encouraged - but not required - to utilize the complaint system of their provider

agency

The next level of complaint is to the DSDS QA unit. The complaint/grievance may be submitted by any person using any entry - phone, letter, email, fax, or personal conversation from recipients of services, family members, providers, friends, general public, State staff reporting from an official capacity or casual observer. Complaints by an agency about state staff or program administration may be submitted through this avenue.

Recipients are informed in writing of their right to submit a complaint/grievance and how to contact the DSDS to place the complaint/grievance is provided during the initial and annual plan of care process. At the same time, recipients are advised of their right to change different providers, (including choosing different care coordinators). During the care plan process the differences between the complaint and grievance process and the fair hearing appeal process are explained verbally and in writing.

The QA staff routinely discusses the participant's right to choose different providers with providers during on site visits and care coordinator training.

(b) the process and timelines for addressing grievances/complaints:
Complaint/grievance is reviewed immediately upon receipt to determine if anyone is at risk of harm. Per AS 47.17.010 for children and AS 47.24.010 for adults, referral to Adult Protective Services (APS) and the Office of Childrens Services (OCS) is made immediately if there is any indication of potential abuse, neglect, exploitation.

Beyond the APS/OCS referral, if appropriate, the QA unit investigator develops preliminary information within one working day to determine the priority of the within the DSDS caseload. Prioritization meetings occur within the QA unit at least weekly but more often as warranted by cases with high priority. Highest priority cases are considered to be cases that must be investigated in tandem with APS or OCS, cases where no one is currently at risk of harm, but must be addressed immediately to prevent harm to recipients and/or providers of care.

DSDS QA unit investigators develop the case. Other DSDS program staff contribute information. All DSDS staff may coordinate to conduct field reviews. Coordinated investigations occur as needed with the DSDS QA Unit and the Long Term Care Ombudsman's office, Division of Public Health's, Certification & Licensing Unit, and Adult Protective Services or the Office of Children's Services.

(c) the mechanisms that are used to resolve grievances/complaints

Complaints/Grievances are developed toward various outcomes:
- case specific solution – change in Plan of Care, changing providers or living situations;
- referral to Medicaid Fraud Control Unit;
- coordination to apply sanctions against providers – including re-education of provider, loss of certification, loss of licensure, referral for payment recoupment and/or criminal prosecution;
- DSDS program changes and corrective actions through the Quality Improvement Plan process – including changes in policies and procedures, changes in State staffing, up to promulgation of new regulations or State Statutes.

Aggregating and analyzing complaint/grievance data by QA staff allows for the Quality Improvement Workgroup to identify and implement necessary corrective actions within their control and to raise larger issues to the Quality Improvement Steering Committee for prioritization and resource development.